Complete Summary

TITLE

Coronary heart disease: the percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment.

SOURCE(S)

British Medical Association (BMA) and NHS Employers. Quality and outcomes framework guidance for GMS contract 2009/10. London (UK): British Medical Association, National Health Service Confederation; 2009 Mar. 162 p.

Measure Domain

PRIMARY MEASURE DOMAIN

Process

The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the Measure Validity page.

SECONDARY MEASURE DOMAIN

Does not apply to this measure

Brief Abstract

DESCRIPTION

This measure is used to assess the percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment.

RATIONALE

Coronary heart disease (CHD) is the single commonest cause of premature death in the United Kingdom (UK). The research evidence relating to the management of CHD is well established and if implemented can reduce the risk of death from CHD and improve the quality of life for patients. This measure is one of ten Secondary Prevention of Coronary Heart Disease (CHD) measures. The "Secondary Prevention of Coronary Heart Disease (CHD)" indicator set focuses on the

management of patients with established CHD consistent with clinical priorities in the four nations.

The Quality and Outcomes Framework (QOF) does not specify how the diagnosis of angina is made or confirmed. This will vary from patient to patient, e.g., clinical history, response to medication, results of investigations, hospital letters, etc.

In general, angina is a clinical diagnosis. Patients with suspected angina should have a 12 lead electrocardiogram (ECG) performed. The presence of an abnormal ECG supports a clinical diagnosis of CHD.

An abnormal ECG also identifies a patient at higher risk of suffering new cardiac events in the subsequent year. However, a normal ECG does not exclude coronary artery disease. Refer to the Scottish Intercollegiate Guideline Network (SIGN) guideline, "Management of stable angina" (SIGN Publication No. 96, February 2007) for further information.

As an additional assessment (rarely for diagnosis), patients with newly diagnosed angina should be referred for exercise-testing or myocardial perfusion scanning.

The aim of further investigation is to provide diagnostic and prognostic information and to identify patients who may benefit from further intervention.

Exercise tolerance testing (ETT) has been shown to be of value in assessing prognosis of patients with coronary artery disease. An ETT is also helpful in patients at high risk of CHD, where a positive test can provide useful prognostic information.

Patients should not be referred for an ETT if:

- They are on maximal medical treatment and still have angina symptoms
- The diagnosis of CHD is unlikely (these patients should be referred to a cardiologist)
- They are physically incapable of performing the test
- They have clinical features suggestive of aortic stenosis or cardiomyopathy
- The results of stress testing would not affect management

Refer to the SIGN guideline, 96 (2007) for further information.

Specialist Referral:

An alternative to referral for exercise-testing is referral to a specialist for evaluation. Referral would normally be to a cardiologist, general physician or general practitioner (GP) with a special interest.

PRIMARY CLINICAL COMPONENT

Coronary heart disease; exercise testing; referral for specialist assessment

DENOMINATOR DESCRIPTION

Patients with newly diagnosed angina (diagnosed after 1 April 2003)

NUMERATOR DESCRIPTION

Number of patients from the denominator who are referred for exercise testing and/or specialist assessment*

*__Note__: For the purposes of the Quality Outcomes Framework (QOF) an appropriate referral being undertaken between three months before and twelve months after a diagnosis of angina has been made would be considered as having met the requirements of this indicator.

Evidence Supporting the Measure

EVIDENCE SUPPORTING THE CRITERION OF QUALITY

- A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence
- A formal consensus procedure involving experts in relevant clinical, methodological, and organizational sciences

NATIONAL GUIDELINE CLEARINGHOUSE LINK

- Management of stable angina. A national clinical guideline.

Evidence Supporting Need for the Measure

NEED FOR THE MEASURE

Unspecified

State of Use of the Measure

STATE OF USE

Current routine use

CURRENT USE

Internal quality improvement
National reporting
Pay-for-performance

Application of Measure in its Current Use

CARE SETTING

Physician Group Practices/Clinics

PROFESSIONALS RESPONSIBLE FOR HEALTH CARE

Physicians

LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED

Group Clinical Practices

TARGET POPULATION AGE

Unspecified

TARGET POPULATION GENDER

Either male or female

STRATIFICATION BY VULNERABLE POPULATIONS

Unspecified

Characteristics of the Primary Clinical Component

INCIDENCE/PREVALENCE

Unspecified

ASSOCIATION WITH VULNERABLE POPULATIONS

Unspecified

BURDEN OF ILLNESS

Unspecified

UTILIZATION

Unspecified

COSTS

Unspecified

Institute of Medicine National Healthcare Quality Report Categories

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness

Data Collection for the Measure

CASE FINDING

Users of care only

DESCRIPTION OF CASE FINDING

Patients with newly diagnosed angina (diagnosed after 1 April 2003)*

*__Note__: The Quality and Outcomes Framework (QOF) includes the concept of exception reporting. This has been introduced to allow practices to pursue the quality improvement agenda and not be penalised, where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.

The following criteria have been agreed for exception reporting:

A. patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding twelve months
B. patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, e.g., terminal illness, extreme frailty
C. patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months, e.g., blood pressure or cholesterol measurements within target levels
D. patients who are on maximum tolerated doses of medication whose levels remain suboptimal
E. patients for whom prescribing a medication is not clinically appropriate, e.g., those who have an allergy, another contraindication or have experienced an adverse reaction
F. where a patient has not tolerated medication
G. where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records
H. where the patient has a supervening condition which makes treatment of their condition inappropriate, e.g., cholesterol reduction where the patient has liver disease
I. where an investigative service or secondary care service is unavailable

Refer to the original measure documentation for further details.

DENOMINATOR SAMPLING FRAME

Patients associated with provider

DENOMINATOR INCLUSIONS/EXCLUSIONS

Inclusions
Patients with newly diagnosed angina (diagnosed after 1 April 2003)

Exclusions
See "Description of Case Finding" field for exception reporting.

RELATIONSHIP OF DENOMINATOR TO NUMERATOR

All cases in the denominator are equally eligible to appear in the numerator

DENOMINATOR (INDEX) EVENT

Clinical Condition

DENOMINATOR TIME WINDOW

Time window precedes index event

NUMERATOR INCLUSIONS/EXCLUSIONS

Inclusions
Number of patients from the denominator who are referred for exercise testing and/or specialist assessment*

*__Note__: For the purposes of the Quality Outcomes Framework (QOF) an appropriate referral being undertaken between three months before and twelve months after a diagnosis of angina has been made would be considered as having met the requirements of this indicator.

Exclusions
Unspecified

MEASURE RESULTS UNDER CONTROL OF HEALTH CARE PROFESSIONALS, ORGANIZATIONS AND/OR POLICYMAKERS

The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.

NUMERATOR TIME WINDOW

Fixed time period

DATA SOURCE

Medical record
Registry data

LEVEL OF DETERMINATION OF QUALITY

Individual Case

PRE-EXISTING INSTRUMENT USED

Unspecified

Computation of the Measure

SCORING

Rate

INTERPRETATION OF SCORE

Better quality is associated with a higher score

ALLOWANCE FOR PATIENT FACTORS

Unspecified

STANDARD OF COMPARISON

External comparison at a point in time
Internal time comparison
Prescriptive standard

PRESCRIPTIVE STANDARD

Payment stages: 40-90%

EVIDENCE FOR PRESCRIPTIVE STANDARD

British Medical Association (BMA) and NHS Employers. Quality and outcomes framework guidance for GMS contract 2009/10. London (UK): British Medical Association, National Health Service Confederation; 2009 Mar. 162 p.

Evaluation of Measure Properties

EXTENT OF MEASURE TESTING

Unspecified

Identifying Information

ORIGINAL TITLE

CHD 2. The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment.

MEASURE COLLECTION

Quality and Outcomes Framework Indicators

MEASURE SET NAME

Secondary Prevention of Coronary Heart Disease (CHD)

DEVELOPER

British Medical Association
National Health Service (NHS) Confederation

FUNDING SOURCE(S)

The expert panel who developed the indicators were funded by the English Department of Health.

COMPOSITION OF THE GROUP THAT DEVELOPED THE MEASURE

The main indicator development group is based in the National Primary Care Research and Development Centre in the University of Manchester. They are: Professor Helen Lester, NPCRDC, MB, BCH, MD; Dr. Stephen Campbell, NPCRDC, PhD; Dr. Umesh Chauhan, NPCRDC, MB, BS, PhD.

Others involved in the development of individual indicators are: Professor Richard Hobbs, Dr. Richard McManus, Professor Jonathan Mant, Dr. Graham Martin, Professor Richard Baker, Dr. Keri Thomas, Professor Tony Kendrick, Professor Brendan Delaney, Professor Simon De Lusignan, Dr. Jonathan Graffy, Dr. Henry Smithson, Professor Sue Wilson, Professor Claire Goodman, Dr. Terry O'Neill, Dr. Philippa Matthews, Dr. Simon Griffin, Professor Eileen Kaner.

FINANCIAL DISCLOSURES/OTHER POTENTIAL CONFLICTS OF INTEREST

None for the main indicator development group.

ENDORSER

National Health Service (NHS)

ADAPTATION

Measure was not adapted from another source.

RELEASE DATE

2004 Apr

REVISION DATE

2009 Mar

MEASURE STATUS

This is the current release of the measure.

This measure updates a previous version: British Medical Association (BMA), and NHS Employers. Quality and outcomes framework guidance for GMS contract 2008/09. London (UK): British Medical Association, National Health Service Confederation; 2008 Apr. 148 p.

SOURCE(S)

British Medical Association (BMA) and NHS Employers. Quality and outcomes framework guidance for GMS contract 2009/10. London (UK): British Medical Association, National Health Service Confederation; 2009 Mar. 162 p.

MEASURE AVAILABILITY

The individual measure, "CHD 2. The Percentage of Patients with Newly Diagnosed Angina (Diagnosed after 1 April 2003) Who Are Referred for Exercise Testing and/or Specialist Assessment," is published in the "Quality and Outcomes Framework Guidance." This document is available from the British Medical Association Web site.

NQMC STATUS

This NQMC summary was completed by ECRI on September 18, 2006. The information was verified by the measure developer on November 1, 2006. This NQMC summary was updated by ECRI Institute on January 7, 2009. The information was verified by the measure developer on February 9, 2009. This NQMC summary was updated again by ECRI Institute on September 25, 2009. The information was verified by the measure developer on March 4, 2010.

COPYRIGHT STATEMENT

Disclaimer

NQMC DISCLAIMER

The National Quality Measures Clearinghouse™ (NQMC) does not develop, produce, approve, or endorse the measures represented on this site.

All measures summarized by NQMC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public and private organizations, other government agencies, health care organizations or plans, individuals, and similar entities.

Measures represented on the NQMC Web site are submitted by measure developers, and are screened solely to determine that they meet the NQMC Inclusion Criteria which may be found at http://www.qualitymeasures.ahrq.gov/about/inclusion.aspx.

NQMC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or its reliability and/or validity of the quality measures and related materials represented on this site. The inclusion or hosting of measures in NQMC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding measure content are directed to contact the measure developer.

Copyright/Permission Requests

Date Modified: 4/19/2010